CHELLIAH MANICKAM & ANOR

v.

KERAJAAN MALAYSIA

HIGH COURT MALAYA, PENANG
JEFFREY TAN JC
[CIVIL APPEAL NO: 12-78-94]
12 AUGUST 1995

TORT: *Negligence - Professional negligence - Wrong diagnosis by doctor - Failure to consider other causes - Patient operated on for appendicitis which did not exist - Surgery a last resort for actual ailment of pancreatitis - Failure of doctor to carry out relevant test to confirm diagnosis - Failure to review X-ray before carrying out surgery - Whether doctors had exercised standard of skill of a competent medical doctor exercising and professing to have that skill*

The appellants were the parents of a girl aged 10 years who had died whilst being treated at the Penang General Hospital, which was run by the respondent. The appellants alleged that the doctor attending to their daughter at the hospital had wrongly diagnosed her condition as an inflamed appendix. As a result surgery was carried out to remove the appendix. However, as the doctors were performing the operation, they realised that the child was not suffering from acute appendicitis and closed the wound. She died the following morning, on 5 July 1990. It was not in dispute that: (i) the child died of acute haemorrhagic pancreatitis and not of an acute perforated appendicitis; (ii) the accepted treatment for perforated appendicitis is surgery; (iii) the treatment for acute pancreatitis should be conservative; and (iv) surgery for pancreatitis 'is bad and a last resort'. The Sessions Court judge held at first instance in favour of the hospital. The appellants appealed. The issue for determination was whether the doctors at the hospital were negligent in their diagnosis and treatment of the appellants' daughter, having regard to the standard of skill or competence of a medical doctor exercising and professing to have that skill.

Held:

[1] The facts established: (i) that the child's appendix was normal and that the symptoms exhibited were of acute haemorrhagic pancreatitis and not acute appendicitis. The stomach pain and tenderness, vomiting, low-grade fever and sluggish bowel sounds with no pain over the right illiac-fossa ('RIF'), should have alerted the doctor to the possibility of pancreatitis, especially since sluggish bowels sounds was not a symptom of acute

appendicitis; (ii) the X-ray taken of the child had not been reviewed before the operation was carried out although there had been sufficient time to do so; (iii) the doctor had failed to carry out a serum amylase test which, together with the X-ray, could have confirmed her condition as pancreatitis; and (iv) the surgery, had added further trauma to an already traumatised child and had hastened her death.

[2] Consequently there was a failure to exercise the care and attention which the circumstances demanded from an ordinary competent doctor. That failure was not in the wrong diagnosis but in the myopic and inflexible approach in the diagnosis.

[3] On a balance of probabilities, the child had died as a consequence of the wrong treatment.

[4] The respondent was ordered to pay the appellants RM10,000 as damages for bereavement, RM1,000 for funeral expenses, interest on the judgment sum at the rate of 4% pa from the date of death to the date of judgment, and at 8% pa thereafter to the date of realisation, and costs of the appeal and trial.

[Appeal allowed.]

Cases referred to:

Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582 ***(foll)***
Chin Keow v. Government of Malaysia [1967] 2 MLJ 45 ***(aff)***
Inderjeet Singh Piara Singh v. Mazlan Jasman & Ors [1995] 3 CLJ 395 ***(refd)***
Kathavarayan v. Ng Sup Moi & Anor [1987] 1 MLJ 246 ***(refd)***
Mariah Mohamed (Administratrix of the estate of Wan Salleh bin Wan Ibrahim, deceased) v. Abdullah bin Daud (Dr Lim Kok Eng & Anor, Third Parties) [1989] 2 CLJ 1232 ***(refd)***
Swamy v. Mathews & Anor [1968] 1 MLJ 138 ***(foll)***
Wong Mei Choon & Anor v. Dr. Kuldeep Singh & Anor [1985] 2 MLJ 373 ***(refd)***

Other sources referred to:

34 Halsbury's Laws, 4th edn, para 123
The British Medical Association's Complete Family Health Encyclopedia (Published 1990)
An Aid to Clinical Surgery, HAF Dudley, 2nd edn, p 155

For the appellant - M Thayalan; M/s Meena, Thayalan & Partners
For the respondent - Syed Marzidy, FC

Reported by Anne Khoo

JUDGMENT

Jeffrey Tan JC:

This is an appeal against the judgment of the Georgetown Sessions Court, dismissing with costs the appellants/plaintiffs' action for damages arising from the death of their daughter, a child of 10, whilst she was treated at the Penang General Hospital.

The facts before the trial court may be summarised as follows. On the morning of 4 July 1990, a private medical practitioner (PW4) examined the appellants' daughter, Nithiah a/l Chelliah (the child), and referred her to the Penang General Hospital. At the Penang General Hospital, the child was diagnosed as suffering from a perforated appendicitis, and an appendectomy (also called appendicectomy), the surgical removal of what should have been an inflamed appendix, was performed at about 5.45 pm on 4 July 1990. However, as the doctors were performing the said appendectomy, they realised that the child, contrary to their earlier prognosis, was not suffering from acute perforated appendicitis. They removed some fluid and closed the surgical wound. The following morning, 5 July 1990 at about 5.25 am, the child died at the Penang General Hospital. The child was eventually diagnosed as suffering from acute haemorrhagic pancreatitis.

It was not in dispute, in the trial below and in this appeal, (i) that the child died from acute haemorrhagic pancreatitis that doctors at the Penang General Hospital had wrongly diagnosed as acute perforated appendicitis, (ii) that the accepted treatment for acute perforated appendicitis is surgery, (iii) that a patient suffering from acute pancreatitis should be treated conservatively, and, (iv) that surgery on patients suffering from pancreatitis "is bad and is a last resort". The trial Judge who noted the latter undisputed facts, remarked in her grounds, "the main issue for determination is whether the misdiagnosis by the defendants' servants amounted to negligence".

In the appeal, Mr. Thayalan Muniandy, learned Counsel for the appellants, submitted at length on the material parts of the evidence of the three (3) doctors who testified, and he contended that the doctors at the Penang General Hospital should have correctly diagnosed the acute pancreatitis, as the 4 confirmed symptoms prior to surgery, namely, (i) nausea (ii) abdominal pain (iii) fever and (iv) sluggish bowels, should have alerted them to the possibility of pancreatitis. The doctor (DW1) who wrongly diagnosed acute appendicitis agreed there should be pain, in the case of appendicitis, over the right illiac-fossa (RIF). However, in the instant case, there was no such pain over the RIF. Yet, DW1 only considered, because it is common, the possibility of appendicitis, but not pancreatitis. Mr. Thayalan further contended that DW1's

disagreement that a serum amylase test would have detected the pancreatitis, was against the weight of the medical evidence of the other doctors (PW4 and DW2), and that PW4's referral (P2) to the Penang General Hospital was sufficient notice that there was something unusual in the child's condition.

Tuan Syed Marzidy, learned Federal Counsel, appearing for the respondents, contended however that DW1 had displayed all the necessary skill in his diagnosis and treatment. There was general tenderness in the stomach, and it was therefore difficult to detect the pain in the RIF; DWI related the symptoms to the commonest ailment – appendicitis – and treated the child accordingly. The learned Federal Counsel further contended that the treatment at the Hospital was right and proper, and was not lacking medical skill.

It is said, "persons who hold themselves out as being capable of attaining standards of skill either in relation to the public generally, or in relation to some person for whom he is performing a service, he is required to show the skill normally possessed by person doing that work" (34 *Halsbury's Laws* (4th Edn.) para. 123. *Halsbury's Laws* (*supra*) summarised the standard of skill of doctors and other professions as follows:

> Doctors and members of other professions and callings must, therefore, exercise the standard of skill which is usual in their profession or calling, and it is no defence that they acted to the best of their skill if that falls below the required standard. The obligation to exercise that skill is based on the ground that a reasonable man who owes a duty of care would exercise the care of a skilled man in doing the operation in those circumstances.

McNair J, in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, at 586, expounded it thus:

> But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not ... is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercise the ordinary skill of an ordinary competent man exercising that particular act.

The test of the care and skill of an ordinary competent practitioner was also pronounced in *Chin Keow v. Government of Malaysia* [1967] 2 MLJ 45, and in *Swamy v. Mathews & Anor.* [1968] 1 MLJ 138, the Federal Court, per Barakhah LP, said:

> A man or woman who practises a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession – be it the profession of an accountant, a banker, a doctor, a solicitor or otherwise.

The following cases illustrate the application of the "ordinary competent practitioner test" in the local jurisdiction: -

(i) *Inderjeet Singh a/l Piara Singh v. Maz1an bin Jasman & 2 Ors.* [1995] 3 AMR 2201, where the necessary tests to ascertain whether the patient's uretha was actually ruptured was not carried out and the diagnosis was incorrect, and James Foong J held that there was a failure in exercising a fair and reasonable standard of care expected of an ordinary professional possessing such skill and art when treating the plaintiff.

(ii) *Kathavarayan v. Ng Sup Moi & Anor.* [1987] 1 MLJ 246, where the doctor applied a full length plaster of paris to the left leg, exposing only the toes, of a patient who suffered a close fracture of the upper tibia of his left leg with haemarthrosis to his left knee, and the doctor failed to give due consideration to the presence of haemarthrosis on the left knee or act on the patient's persistent complaint of severe pain or test the nail circulation after the plaster was applied, and Volkmann's Ischemia set in (from the total, or partial interference of blood supply) resulting in the patient's loss of his left leg, and the doctor diagnosed Volkman's Ischemia 15 days after the plaster of paris was applied and it was too late for corrective treatment, and Siti Norma Yaakob J (as she then was) held that there was a failure to provide the plaintiff with the necessary medical care and attention.

(iii) *Mariah bte Mohamed (Administratrix of the estate of Wan Salleh bin Wan Ibrahim, deceased) v. Abdullah bin Daud (Dr Lim Kok Eng & Anor., Third Parties)* [1990] 1 MLJ 240, where Abdul Malek J (as he then was) held that the absence of a computer axial tomogram (CAT scan) for further information as regards the blood clot and fluids in the patient's brain was not negligence, as exploratory bore holes showed that the damage was permanent and no purpose would be served by a CAT scan and as there was no departure from the approved practice in the treatment of the patient.

On the alleged negligence in the instant case, it was a question of fact whether the General Hospital had failed to show reasonable care. In *Wong Mei Choon & Anor. v. Dr. Kuldeep Singh & Anor.* [1985] 2 MLJ 373, where the alleged fact – that fractures present on a patient were not detected when he was examined – was not proved, the Supreme Court held as follows:

> When a *prima facie* case of negligence against the defendant has been established under the doctrine of *res ipsa loquitur*, the defendant can rebut that case by proving that he was not negligent, even though he cannot prove how

> the accident happened. If the defendant can show a way in which the accident may have occurred without negligence, the cogency of the fact of the accident by itself disappears, and the plaintiff is left as he began, namely, that he has to show negligence. It is important that the suggestion of how the accident may have occurred must be shown to be reasonable. If the defendant gives a reasonable explanation which is equally consistent with the accident happening without his negligence he has again shifted the burden of proof back to the plaintiff.

The doctors at the trial did not quite agree on the standard of skill of a medical doctor managing the child and on the standard of care and attention that a medical doctor should have exercised in the circumstances said.

PW4, a private general medical practitioner of 22 years examined the child at 7.45pm on 3 July 1990. The transcript of his testimony reads as follows. The child was complaining of pain in her stomach, but her stool and urine were normal, as were her heart and lungs. On his diagnosis – "acute gastritis and vomiting" – he prescribed medicine to stop the stomach pain and vomiting. The following morning, at 8.30am, he examined the child once more. He detected tenderness in her stomach. He was told that the child was vomiting the previous night. Her condition was serious, and he was of the opinion that she should be admitted to the hospital, for further examination. He wrote a referral (P2), with his diagnosis – "acute intestinal obstruction due to?", to the Penang General Hospital.

PW4 explained that he considered other conditions that would result in acute upper abdominal pain. It could be due to a perforated ulcer, intestinal obstruction or hiatus hernia. Of those possibilities, the most common was acute intestinal obstruction. That was the reason for his query "?" in his referral. PW4 ruled out appendicitis, as there was no right illiac-fossa pain and the child's body-temperature was low-grade.

On the appendectomy and the care and attention given at the hospital, PW4 said the following: he would have an abdomen and thorax x-ray to rule out conditions which may show up; an x-ray would be useful to rule out a perforated appendix, a perforated gastric ulcer (there would be fluid in the diaphragm) acute pancreatitis (there would be pleural effusion in the lungs) and intestinal obstruction (there would be air in the loops of the bowels causing distension); a total white blood count (TWBC) test (which would show appendicitis) and a serum amylase test (which would show pancreatitis but not appendicitis) should have been done before the appendectomy, as it would have detected the child's acute pancreatitis; the Hospital's medical report (P4) was not indicative of appendicitis; an RIF examination was not carried out; the child, after the appendectomy when it was evident was not suffering from appendicitis, should have been placed in the intensive care unit.

PW4 also divulged that patients of acute pancreatitis should be treated conservatively (without surgery) – "to tide over the emergency" – and surgery is a last resort, that an anaesthetist should have assessed the condition of the child "to see if she was a suitable candidate for an operation" and that surgery and anaesthesia caused additional trauma to an already traumatised child; there was a 60% to 75% chance that the child would have survived if she was treated conservatively at the hospital.

PW4 gave the symptoms for acute appendicitis and pancreatitis as follows; for appendicitis, (i) acute RIF tenderness, (ii) persistent vomiting (iii) fluctuating temperature, and for pancreatitis, (i) acute upper abdominal pain (ii) vomiting of a yellowish fluid (iii) difficulty in breathing in some cases, (iv) maybe low grade fever but not as high as in acute appendicitis. The difference, he explained, is the fluctuating and high temperature for acute pancreatitis and acute RIF tenderness for appendicitis.

DW1, a medical doctor attached to the Penang General Hospital, examined the child at 3.00p.m. on 4 July 1990. From him, the transcript has the following evidence. The child was admitted with a history of vomiting, abdominal pain and a fever of 2 days duration. She had a low-grade fever and a coated tongue and she was dehydrated. Her vital signs – the blood pressure, pulse rate and respiratory rate – were normal. There was general tenderness in the abdomen, which was distended, and the bowel sounds were sluggish. DW1 diagnosed a perforated appendix. He did not consider pancreatitis. He did not diagnose other conditions as apendicitis was the most common emergency in cases of abdominal pains. According to DW1, the symptoms for acute pancreatitis are similar to appendicitis, but the pain is initially found in the epigastrium and by pocondrum areas. DW1 recommended an appendectomy. He was one of the doctors who performed the appendectomy. When the abdomen was opened, he and the other doctors found, (i) haemorrhagic peritoneal fluid inside the peritoneum, (ii) fats from the pancreas had diffused to the surrounding areas, (iii) the pancreas were swollen, and (iv) necrosis was seen in the pancreas. The other organs, including the appendix, were normal, but the child was very ill. DW1 and the other doctors concluded that the child was suffering from acute haemorrhagic pancreatitis. They closed the abdomen and sent the child to the recovery room to be nursed. There, the child was closely observed. Her blood pressure, pulse rate and respiratory rate were recorded every half hourly. The child was in the recovery room for 2 hours, and then sent to the ward. The anaesthetist decided that the child be in the recovery room, and he also decided that she be moved to the ward.

DW1 expressed his opinion that when he found that the child was suffering from acute haemorrhagic pancreatitis, she was very ill and her chances of survival were slim. For acute appendicitis, there should be RIF pain, but in the case of a perforated appendix there would not be RIF pain. DW1 disagreed that for acute appendicitis there would be a high body temperature. There was generalised pain and it was difficult "to examine if there was epigastric tenderness". In acute appendicitis, the pain would be in the epigastrium and move to the RIF.

On PW4's tests before surgery, DW1 did not instruct a serum amylase test, but a TWBC was done before the surgery, and the total white blood count was 14,200. An x-ray was taken, but it was not reviewed because of the shortage of time. DW1 disagreed, that (i) it was wrong to diagnose without reviewing the x-ray, (ii) an x-ray would have shown that the patient was not suffering from acute appendicitis, (iii) the serum amylase test, if done before the surgery, would have shown the pancreatitis but not the appendix, (iv) it was wrong not to have considered pancreatitis, (v) he should have done a laparoscopy to determine whether the child was suffering from pancreatitis or appendicitis. He agreed however that local tenderness in the RIF is very important in the diagnosis of appendicitis. He admitted that he knew that an x-ray had been taken when he examined the child at 3.10 pm on 4 July 1990 (the child was operated on about 2 hours after DW1 first saw her) and that there was more than sufficient time (contradicting himself) to review the x-ray before the surgery. On pancreatitis, DW1 agreed that the recommended treatment is conservative treatment and not surgery unless there are complications. DW1 also agreed that the treatment for pancreatitis and appendicitis are different. He confirmed that the treatment for acute appendicitis is surgical intervention while that for acute pancreatitis is conservative treatment.

DW1 defended his management. A serum amylase test was not done as the diagnosis was acute appendicitis. Even if it was done and the result was higher than normal, it would not confirm pancreatitis and would not have altered his management. He could not remember whether an attempt was made to trace the x-ray, but the x-ray would not have made a difference, as it was difficult to confirm from an x-ray alone whether the child was suffering from appendicitis. There was no need for a laparotomy as the diagnosis of appendicitis was confirmed by the clinical examination and by the history, and there was no need to put the child to further trauma.

The last of the triumvirate of medical doctors, DW2, a State Surgeon then attached to the Penang General Hospital, rendered the following testimony. He did not examine the child but P4 was his report. In acute appendicitis, the pain will start from the para umbilical area and epigrastrium and will shift

and localise in the RIF. The other symptoms are vomiting and a low-grade fever. In the case of a perforated appendicitis, the pain will be generalised, the patient will vomit and have a low-grade temperature or a temperature higher than acute appendicitis. In acute pancreatitis, the pain is in the upper abdomen, the patient will vomit and have a low-grade fever. On the notes recorded by DW1, the diagnosis would be perforated appendicitis, but there could be other causes for the same type of symptoms. The treatment, on a diagnosis of a perforated appendicitis was emergency surgery without delay. With the diagnosis of a perforated appendicitis, tests are immaterial as the patient has to be operated as early as possible. It was not necessary to have an x-ray, and an x-ray would not have a bearing on the management. The result of a serum amylase test had no bearing on the management, as the serum amylase results would not be conclusive.

DW2 also expressed his opinion that when a child of 10 has the symptoms as the child had, a medical officer would think of the commonest conditions and not the "rarities". Quite often the pre-operation diagnosis differs from the post-operation diagnosis. Peritoneal fluid was taken during the appendectomy, and the "amylase was raised markedly". Serum amylase taken after the surgery was raised slightly. "Serium calcium done after surgery was slightly low but within normal limits". TWBC taken before surgery was elevated. An anaesthetist decides whether a patient should be sent to the Intensive Care Unit or to the ward. He also decides how long a patient should remain in the recovery bay – a part of the Operation Theatre complex. At the recovery bay, there will be a nurse who will monitore at regular intervals a patient after surgery. An x-ray will not show a perforated appendix, and it is not easy to diagnose pancreatitis from an x-ray. An x-ray, although helpful in the diagnose of pancreatitis, will not be confirmatory. A serum amylase test will be helpful to confirm that a patient is suffering from acute pancreatitis; 15% of acute pancreatitis cases do not have raised serum amylase. An x-ray together with a serum amylase test will help in the diagnosis of pancreatitis.

DW2 gave the following as the symptoms for pancreatitis, namely (i) nausea, (ii) fever (iii) pain in the epigastrium, (iv) fever and sluggish bowels, and said that if a child has those symptoms, a doctor "should be conscious of the possibility of pancreatitis" (see p. 50 of the Appeal Record). DW2 said that DW1 acted properly "in taking the action he did".

It is now necessary to recapitulate the undisputed facts that the trial court specified, to evaluate the evidence of the three doctors touching on the skill of an ordinary competent doctor.

(i) that the child died from acute haemorrhagic pancreatitis that doctors at the Penang General Hospital wrongly diagnosed as acute appendicitis,

(ii) that the accepted treatment for appendicitis is surgery,

(iii) that a patient suffering from acute pancreatitis should be treated conservatively, and,

(iv) that surgery on patients suffering from pancreatitis "is" bad and is a last resort".

However the above undisputed facts were not the only established facts, as it was also established, either from the whole body of evidence or from reasonable deductions and inferences:

(v) that the child's appendix was normal, and the symptoms that were exhibited, whatever it was, were that of acute haemorrhagic pancreatitis and not acute appendicitis or a perforated appendix,

(vi) that the x-ray taken before the child was examined at 3.10p.m. was not reviewed even at 5.45p.m when the appendectomy was perfomed,

(vii) that the appendectomy, said with the benefit of hindsight, was surgical intervention that could not enhance the child's chances of survival, unlike surgical intervention for acute pancreatitis, where doctor and patient would be prepared, most reasonably, for the risk of the surgery that could improve the child's chances of survival,

(viii) that the appendectomy added further trauma to the child (DW1 said there was no need for a laparoscopy as it would put the child to further trauma),

(ix) that the appendectomy, by reason that the child was dead within 12 hours from the appendectomy, hasten the child's death, if at all it was true that the child's chances of survival even if the appendectomy was not performed was slim,

(x) that the x-ray, and DW1 said it would not have affected his management, if favourable to the defence would have been produced; why else would DW1 be that indifferent to the x-ray - he did not review the x-ray, made an attempt to locate it or even aware if there were attempts to locate it, and it should be in the hospital - when his own professional reputation was at stake.

The child's symptoms, when she was clinically examined by PW4, were stomach pain and tenderness of the stomach, vomiting and a low-grade fever, but without RIF pain (see P2). Her symptoms, when she was clinically examined by DW1, were a low-grade fever, a coated tongue, dehydration, general tenderness in the stomach which was distended, and sluggish bowel sounds; DW1, who said that the child was admitted with a history of vomiting, abdominal pain and a fever of two days, must also have known of the symptoms of vomiting and abdominal pain.

DW2, who did not examine the child and only imparted his medical knowledge, testified that the symptoms (i) for acute appendicitis are, pain starting from the para umbilical area and epigastrium and shifting to the RIF where it will localise, vomiting, and a low grade fever, (ii) for a perforated appendicitis are, generalised pain, vomiting and a low grade temperature or a temperature higher than acute appendicitis, (iii) for acute pancreatitis are, pain in the upper abdomen, vomiting and a low grade fever.

Collocating what the three doctors said are the symptoms of acute appendictis, perforated appendicitis and acute pancreatitis, the following symptoms were voiced by all the doctors;

(i) acute appendicitis – acute RIF tenderness, vomiting and fever,

(ii) pancreatitis – acute upper abdominal pain, vomiting and a low grade fever,

(iii) and with regard to a perforated appendicitis, DW1 and DW2 testified that the symptoms are generalised pain, vomiting and a low grade fever (or a higher temperature but not as high as appendicitis)

Intriguingly, both DW1 and DW2 did not say that the sluggish bowel sounds that DW1 detected when he clinically examined the child is a symptom of a perforated appendicitis, the very diagnosis that brought about the appendectomy that DW1 and DW2 defended. Also intriguingly, DW2 agreed that a doctor should be conscious of the possibility of pancreatitis if the symptoms are nausea, fever, sluggish bowels and pain in the epigastrium (see p. 50 of the Appeal Record).

According to DW1 and DW2, the RIF pain, due to the generalised tenderness of the stomach, was difficult to detect. Yet, even accepting that the RIF pain or absence thereof was difficult to detect such that the symptoms detectable resembled that of a perforated appendicitis, the sluggish bowel sounds - and DW1 said something was wrong with the bowels – was not one of DW1 and DW2's stated symptoms of a perforated appendicitis, and it required therefore

a consideration, but was not, of other causes. The x-ray taken more than 2 hours before the appendectomy was not reviewed. The possibility of pancreatitis did not even cross DW1's mind.

Both DW1 and DW2 said that the x-ray would not be conclusive, and that the tests that PW4 advanced would not be helpful and would not have changed the management, as the diagnosis of a perforated appendicitis was confirmed. DW1 disagreed with all overtures that any one of the tests was of any help in his diagnosis.

The British Medical Association's Complete Family Health Encyclopedia (Published 1990), a medical reference for use in the home, and not intended, presumably so, for ordinary competent doctors, furnishes the following information on appendicitis and pancreatitis and its diagnosis, which is now reproduced *in extenso*.

> Appendicitis
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> Acute inflammation of the appendix which is a common cause of abdominal pain and peritonitis (inflamation of the lining of the abdominal cavity) in children and young adults.
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> Incidence - Appendicitis affects about 200 per 100,000 people per year. Although anyone can get appendicitis, it is rare in the very young and the very old. It is the most common abdominal surgical emergency in developed countries but is comparatively rare in developing countries.
>
> Diagnosis - Diagnosis can sometimes be difficult because the symptoms of appendicitis are similar to those of many other abdominal disorders. Mesenteric adenitis, which is common in children and often follows a viral respiratory tract infection, has symptoms and sign that resemble those of appendicitis. Disorders of the right fallopian tube and ovary, Cohen's disease and right sided pyelonephritis (inflamation of the kidney) can sometimes mimic appendicitis. Sometimes a laparotomy (surgical investigation of the abdomen) is necessary to confirm or exclude a diagnosis of appendicitis.
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> Complications - If treatment is delayed, an inflamed appendix may perforate, releasing its contents into the abdomen. At this point, the pain abruptly ceases, but the perforation leads inevitably to peritonitis. In some cases, the omentum (fold of peritoneum covering the intestines) envelops the inflamed appendix; this prevents the spread of infection and results in a localized abscess around the appendix. Peritonitis or an abscess causes a fever (sometimes with chills) as well as increasing pain and tenderness in the abdomen. This pain first appears a few hours to a day or so after the appendix ruptures.
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> Treatment - The usual treatment is appendicetomy (surgical removal of the appendix). If an abscess of the appendix is suspected, drainage of the abscess and an appendicectomy may be delayed until the infection has been treated by large doses of antibiotic drugs.

Pancreatitis

Causes - The main causes of acute pancreatitis are alcohol abuse and gallstone. Less commonly, pancreatitis results from a viral infection (such as mumps or hepatitis), injury (such as may be caused by a strong blow to the abdomen), surgery on the biliary tract, or certain drugs (such as diuretic drugs and sulphonamide drugs).

Chronic pancreatitis is most commonly caused by alcohol abuse. In rare cases, chronic pancreatitis occurs in people with hyperlipidaemias (a group of disorders characterized by high levels of fat in the blood) or haemochromatosis (a disorder in which there is an excess of iron in the body). Chronic pancreatitis may also rarely be inherited or result from a severe attack of acute pancreatitis.

Symptoms and Diagnosis - Acute pancreatitis produces a sudden attack of severe upper abdominal pain, often accompanied by nausea and vomiting. In many cases, the pain spreads to the back. The pain of acute pancreatitis is usually made worse by movement, and may be relieved by adopting a sitting position. An attack, which usually lasts for about 48 hours, is accompanied by the release of digestive enzymes from the pancreas directly into the blood; measurement of these enzymes is an important diagnostic test. Ultrasound scanning or CT scanning may also be performed.

Chronic pancreatitis usually produces the same symptoms as acute pancreatitis,, although the pain may last from hours to several days, and attacks become more frequent as the condition progresses. However, in some cases there may be no pain and the principal signs may be malabsorption (due to a deficiency of pancreatic enzymes) or diabetes mellitus (due to insufficient insulin production by the pancreas). Measuring pancreatic enzyme levels in the blood is of little value in diagnosing chronic pancreatitis, although measurement of the output of such enzymes into the duodenum (by means of a fine tube passed through the stomach) may be useful. Abdominal X-rays or scans are the usual diagnostic methods, along with endoscopic examination of the pancreatic ducts (see ERCP) to determine the extent of tissue damage.

Treatment - There is no specific remedy for acute pancreatitis. Treatment consists of narcotic analgesic drugs to relieve pain, and the administration of fluids and salts by intravenous infusion. Patients are not allowed to eat or drink because this would stimulate pancreatic a activity and make the symptoms worse. A recurrence of the condition can sometimes be prevented by treating an underlying cause. Occasionally, surgery is necessary to remove the pancreas (see Pancreatectomy) or to remove any gallstones.

Chronic pancreatitis is treated by providing pain relief, by controlling diabetes mellitus with insulin, and by giving pancreatin (a preparation of pancreatic enzymes). In some cases, pancreatectomy may be necessary to relieve pain (all emphasis added).

Diagnostic tests to establish the diagnosis of pancreatitis is also revealed in *"An Aid to Clinical Surgery"* (2nd Edn.) by H.A.F. Dudley, at p. 155.

> Acute pancreatitis. The presence of severe abdominal pains passing through to the back and causing the patient to roll about, in addition to a past history of heavy alcohol intake, should arouse suspicion. A negative abdominal x-ray together with an elevated serum amylase will usually establish the diagnosis of pancreatitis but in a doubtful case a laparotomy will be indicated (emphasis added).

Therefore, on the authority and weight of the above medical bibliotheca, the utility and the benefit of diagnostic tests in the diagnosis of appendicitis and pancreatitis is not as unproductive as DW1 had made it out to be. Indeed, the transcript reveals that even DW1 agreed, when he was cross-examined, and DW1 had decidedly played down the benefit of diagnostic tests in his diagnosis, with the compendious p. 1.55 (see p. 44 of the Appeal Record).

Indeed, the above medical bibliotheca endorse what PW4 advanced on the abdomen and thorax x-ray [and PW4's explanation on the benefit of an x-ray – useful to rule out a perforated appendix a perforated gastric ulcer (there would be fluid in the diaphragm) acute pancreatitis (there would be pleural effusion in the lungs) and intestinal obstruction (there would be air in the loops of the bowels causing distension) – were not answered by DW1 and DW2] the laparotomy and the serum amylase test.

Perhaps the failure to rely on a single diagnostic test was a matter of individual choice from a basket of equally effective diagnostic techniques. However, the failure to take pancreatitis into account when the appendectomy was considered and then executed, bearing in mind that all three doctors agreed that surgery is anathema to a patient suffering from pancreatitis, and because the surgery to be undertaken would put such a patient into danger, and like the penicillin administered in *Chin Yeok* where the doctor was put to reasonable inquiry, and prudence required the exclusion after consideration of that possible but nonetheless real danger to such a patient, was a lack of reasonable foresight and vigilance. Taken together, the failure to review the x-ray, and DW1 admitted there was sufficient time so to do, the failure to use diagnostic tests despite its applicability to confirm appendicitis, and the failure to consider pancreatitis when undertaking the appendectomy, amounted to a failure to exercise that care and attention which the circumstances demanded from even an ordinary competent doctor. The failure was not that the diagnosis was wrong, but the myopic and inflexible approach in the diagnosis – no need to consider other possible causes because appendicitis is common; no need to confirm or disprove the diagnosis – that debased the diagnosis so, when there was a duty to diagnose competently, that it was not a diagnosis at all of an ordinary competent doctor.

a In the final analysis, the child suffering pancreatitis was diagnosed and treated for a perforated appendix, and she died, on a balance of probabilities, as a consequence of that wrongful treatment. It was a blunder squarely on the hospital's doorstep that the defence failed to reasonably explain how it could have occurred without the negligence of the respondent's servants. Instead, the *b* defence revealed the callousness of the respondent's servants, typified best by the post-appendectomy management, where the child, when there was a duty on the respondent's servants to assuage the adverse effects of the appendectomy, was left in the ward, after 2 hours in the recovery bay, to her own devices, to live or to die. That could not be right.

c Accordingly, allowing the appeal and reversing the judgment of the sessions court, and on the quantum of damages agreed to between the parties, it is hereby ordered, (i) that the respondent do pay to the appellants the sum of RM10,000 as damages for bereavement, the sum of RM1,000 as damages for funeral expenses, interests on the judgment sum at the rate of 4% pa from *d* the date of death of the child to 12 August 1995 and at the rate of 8% pa from 13 August 1995 to the date of satisfaction, (ii) that the respondent do pay to the appellants the costs of this appeal and below.

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